Prevention Guidelines for Adult Health
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Texas Nurse Practitioners 2014

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Americans need prevention
Nearly 2 million quality-adjusted life years would be saved if utilization rates were improved for just three services:

- tobacco-use screening and brief intervention,
- colorectal cancer screening, and
- influenza immunization.

Satcher, D., 2006

Three Main Types of Clinical Preventive Care

- Screening
- Behavioral counseling
- Preventive Medications

Screening

Think Risk Factors for most LIKELY diseases
Identifying Risk Factors

• Age/Gender/Racial-Ethnic
• Personal and Family Risks

• A RF that is present in BOTH areas is a significant risk (e.g., obesity with diabetes)

What RFs/Problems Should You Address?

• Recent study showed that it would take almost ___ time?___ per day to address all major risks & counseling topics for a typical pt load WITHOUT doing anything else for the pts

• Will require your scientific & artistic judgment to prioritize topics

• Need a “smart system” to assist you

Caveats re Prevention

• 7.4 hours DAILY to offer all U.S. Guide to Clinical Prevention Services in Family Practice (American Jour Public Health, April 2003)

• Average patient in a Family Practice waiting room needs 25 preventive services
So, WHAT do you decide to do, with whom, when, & how?

What is your system?

A Day in the Life of a Busy NP....
NPs working with Prevention

- How many have a perfect system for defining & implementing prevention guidelines?
- How many approach implementing prevention in your daily practice using
  - EHR patient summaries provided to you?
  - Flow sheets?
  - Role of MA or other staff?
  - Other?

Major Findings Stone et al.

- Striking result: dramatic effect of organizational change, esp teamwork.
  - Identify & deliver prevention as part of routine care (e.g., standing MA orders, Nurse case managers)
- System of pt reminders can be effective
- Relative ineffectiveness of provider feedback 😞
- Pt or provider education consistently less effective 😞
Prioritizing Prevention: What’s the Best Evidence?

- United States Public Services Task Force (USPSTF)
- Institute for Clinical Systems Improvement (ICSI)
- Partnership for Prevention
Judging Value/Evidence of Prevention Services

• Levels of Evidence:
  – A: recommends the service. There is high certainty that the net benefit is substantial.
  – B: recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.
  – C: recommends against routinely providing the service – Benefit small if present
  – D: recommends against the service – harm > benefit
  – I: current evidence is insufficient

Evidence Level Summary

• Do (A & B)

• Don’t Do (C & D)

• Don’t Know (I)
USPSTF E-Tool (free) Fantastic Resource!!!

- ePSS (Electronic Preventive Services Selector)
- Available for smart phone and web
- Apps store AHRQ or EPSS
- Can print from web for pt handout

ALSO, great, FREE Pocket Guide resource from AHRQ
What services are considered preventive care & required by ACA in 2015?

**Items or services recommended with an A or B rating by the U.S. Preventive Services Task Force**

Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) of the CDC

**A & B Ratings USPSTF**
D Ratings

- screening adults for COPD using spirometry
- screening for asymptomatic carotid artery stenosis (CAS) in the general adult population
- routine screening for AAA in women
- screening for testicular cancer in adolescents or adult males
- routine screening for ovarian cancer
- Routine PSA screening in healthy men & PSA testing

USPSTF Grade “D” (selected) recommends against “harm > benefit”
- teaching breast self-examination (BSE)
- routine use of aspirin and nonsteroidal anti-inflammatory drugs (NSAIDs) to prevent colorectal cancer
- Routine screening of women >65 for cervical cancer if adequate recent normal Paps and low risk
- routine Pap smear screening in women who have had a total hysterectomy for benign disease.
- screening for colorectal cancer in adults older than age 85 years
USPSTF (Selected) Grade “I” current evidence is insufficient

- screening for osteoporosis in men
- screening for thyroid disease in adults
- counselling in primary care settings to promote physical health
- Screening Chlamydial infection for men
- screening adults for oral cancer
- Screening mammography in women > 75 years
- CBE breast cancer screening in women
Another way to consider prevention using Over or Under 50 years of age:

<table>
<thead>
<tr>
<th>Service</th>
<th>Population</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac risk assessment for abdominal aortic aneurysm</td>
<td>Never-smoking men ages 65 to 75</td>
<td>2005</td>
</tr>
<tr>
<td>Low-risk family history</td>
<td>Men without family history for CVD and/or low readiness for change</td>
<td>2003</td>
</tr>
<tr>
<td>Lipid disorders</td>
<td>Men ages 30 to 55 and risk factors years with no change</td>
<td>2006</td>
</tr>
<tr>
<td>Cancer</td>
<td>Women ages 40 to 69, individuals with breast cancer history, or having a strong family history of breast cancer</td>
<td>2009</td>
</tr>
<tr>
<td>Screening for colorectal cancer</td>
<td>Men and women ages 76 to 85 years</td>
<td>2009</td>
</tr>
<tr>
<td>Sexually transmitted infections</td>
<td>Low-risk women; low-risk pregnant women age 25+</td>
<td>2007</td>
</tr>
<tr>
<td>Other conditions</td>
<td>Selected screening based on risk factors and family history</td>
<td>2012</td>
</tr>
</tbody>
</table>

C: Low priority, provide only for individual considerations.

## Prevention Screening

### Other Guidelines

- AHRQ National Guidelines Center
- American Cancer Society
- American Heart Association
- American Diabetes Association
- National Heart, Lung & Blood Institute
- Other professional societies as indicated

Selected* Screening Guidelines 2014
* clinicians have most questions about these and/or contain recent changes or additions

Screening Guidelines as of 2014

**Colorectal Cancer Screening (ACG, 2009)**

**New grouping of screening tests:**

- **1. Cancer Prevention (can remove pre and cancerous polyps) tests** VS
- **2. Cancer Detection tests**
Colorectal Cancer Screening

- Begin at age 50 for average risk to age 75, “A”
- Age 45 for AA,
- 10 yrs earlier (40 or 35) if
  + family hx or inflammatory bowel disease
- Age 76-84 screening “I”
- Age >85 “D”

CRC Screening Prevention Tests

1. *Preferred test is colonoscopy q 10 years beginning at age 50 (Sens: 75-90%)
2. * OR Flex Sig q 5-10 years or (Sens 80%)
3. Double Contrast Barium Enema—ACS approves if needed (Sens: 90%, Spec: 99%
  Connolly, 2002)
4. CTC (virtual colonoscopy) q 5 years must have regular colonoscopy if + colon finding

Use of CTC for Screening

- “Federal entities such as USPSTF, CMS, and the V.A., do not recommend CTC for screening of asymptomatic individuals 50 years and older.
- Considerable variation exists in the recommendations of professional organizations.
- Many, but not all, private/ third-party insurers cover CTC for CRC screening”.
Colorectal Cancer Screening: Detection

- Cancer Detection Tests

1. FIT fecal immunochemical test (BEST & Preferred test for now) (Sen: 40%, Spec: 97%).
   - Annually x 3 specimens NOT once in exam room

2. Medicare approved fecal DNA stool test (8/2014): $599 Cologuard test detects DNA changes associated with colon cancer and advanced adenomas

Breast Cancer Screening

- Some controversy re start age & frequency for MAMMOGRAM

Starting:
- 40 and annually (ACS)
- 50 biannual (before 50, individualize & use pt context to decide if do earlier) (USPSTF) note: ACA uses 2002 guide to start at 40.

Stopping:
- no proven benefit past 75 (depends on pt & life expectancy) (USPSTF)
- as long as good health (ACS)

Breast Cancer Screening

• CBE
  - q 2-3 years <40, annually >40 (ACS)
  - insufficient evidence “I” (USPSTF)

• BSE
  - an option; no proven benefit “D” (USPSTF)

• MRI + mammo
  - >20% lifetime risk (<2% U.S. women at this risk level)

• 3D mammogram
Newer Breast Cancer Topics

• Discuss chemoprevention for high risk breast cancer “B” 2013

• Family HX Risk Assessment & referral IF indicated for BRAC mutation counseling (breast & ovarian) “B” 2013

Cervical Cancer Screening Guidelines

<table>
<thead>
<tr>
<th>When to start?</th>
<th>USPSTF, ACS 2012, ACOG 2009, ICSI 2011</th>
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<tbody>
<tr>
<td>Age 21-65 regardless of sexual activity</td>
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<table>
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<tr>
<th>Intervals?</th>
<th>Conventional Pap test</th>
<th>Liquid-Based cytology</th>
<th>HPV testing used &quot;co-testing&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 21-29: Cytology every 3 years. (No HPV unless refer with abnormality= ACS)</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Same as above</td>
<td></td>
<td></td>
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<tr>
<td>Age 30-65: HPV testing with cytology every 5 years. (May to extend screening periods)</td>
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| Use of HPV test <29 yrs "D" |

Cervical Cancer Screening Guidelines (cont.)

<table>
<thead>
<tr>
<th>When to Stop?</th>
<th>USPSTF, ACS 2012, ACOG 2009, ICSI 2011</th>
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<tr>
<td>&gt;=65 with adequate consecutive negative tests; may stop if any cervical cancer &gt;20 years ago; do NOT need to restart if newly sexually active</td>
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<table>
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<tr>
<th>Post Total Hyst?</th>
<th>DC if done for benign reasons and no prior hx high grade CIN</th>
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Prostate Cancer Screening
• Controversy exists regarding screening for Prostate Cancer (ACS)

• Question is whether routine population screening with the PSA test reduces mortality from prostate cancer—limited compelling data that it does

• Issue: Benefit vs Risk of screening and overtreatment

So, what do you do with your patients?
• Educate them that we do not have final answers regarding the advisability of routine screening
• Pts need to understand the benefits and limitations of testing and possibility of overtreatment and they need to make an informed decision

Prostate Cancer Screening
• ACS and USPSTF do NOT recommend routine screening (Rating D) but ACS does recommend shared decision-making with pts to decide
• Start conversations at 50 unless higher risk than average (AA 45, 1st degree relative)
• USPSTF & ACS say can stop screening if doing it at 75 or if < 10 yrs life expectancy
Issues in Prostate Screening (implications for other screenings)

• Widespread screening before high-level evidence available
• Lack of consensus among prof societies
• Concerns that even if counsel & document, may not prevent litigation
• Significant time to educate pts re decision
• Public enthusiastic about cancer screening

(Solarus TA et al, 2011)

Lung Cancer Screening 2013

• National Lung Screening Trial (NLST)
• Annual Low dose CT in adults “B” :
  - 55-80 years
  - 30 pack-year hx
  - Currently smoke or in past 15 years (can stop screening if non-smoker over 15 years)

Selected 2013 & 2014 Recommendations

• HIV Screening 15-65 “A”
• Hepatitis B one time if born 1945-1965 “B”
• Alcohol Misuse Screening & Behavioral Counseling in Primary Care “B”
• Vitamin Supplements for Prevention CVD or cancer: beta carotene or Vit E “D”
Selected 2013 & 2014 Recommendations

- Glaucoma “I”
- Oral screening “I”
- Cognitive Impairment Screening “I”

NOTE: “Lifeline” screening ultrasound tests are NOT indicated for routine screening for anyone—low pretest probability in general population leading to many false positives.

Decide HOW you are going to Identify & Monitor Risk Factors in your practice. If you don’t have a plan, it will never happen!!!

e.g., flowsheets, role of MA, waiting room/exam room pt survey, EHR smart message etc
Medicare Prevention Visit

- New to Medicare for Prevention Visit
- Annual Wellness Visit

Pt Guide
Preventive Meds

Immunizations (see CDC immunization guidelines!!!)

- Influenza starting at 6 months

- TD q 10 years (Tdap at least once as adult) to protect from pertussis
  - 1X Tdap >65 if around infants (timing does not matter)

- Pneumovax at 65 or >18 if smoker or any chronic pulmonary condition (repeat if given <65 & at least 5 years ago)

Preventive Medications cont

- Hep B series as indicated (new: diabetes)

- HPV4 vaccinate females & males (9 to 26 years) best at 11-12 yo

- Zostavax for zoster prevention at 60 yo (FDA approved at 50)

- Meningococcal as indicated

- See others ACIP/CDC

Preventive Meds

- ASA as indicated 81 mg “A”
  - Men >45-79 for MI; Women >55-79 (reduced CVA)
  - Assess risk for GI bleed and decide 2010

- Omega 3 fatty acids (fish oil) DHA, EPA 1-2 grams QD or fatty fish twice weekly

- (Vitamin C & E NOT indicated and may cause harm)

- Calcium with vit D for FX prevention “D”
  - Many outstanding questions re MI risk
  - Dietary sources show no risk so encourage

- Miscellaneous
  - Mediterranean Diet & DASH diet for everyone!
Counseling another key aspect of Prevention

- We counsel many more topics than we have evidence for. See EpSS
- Folic acid (pre conception)
- Drug & ETOH use
- STDs and HIV
- Injury prevention (seatbelts, home safety, fire/smoke alarms, guns)
- Polypharmacy
- NOTE: AHRQ guidebook excellent for key counseling facts.

Primary Care is sooo challenged to do counseling:

- No dedicated time for counseling and assessing for understanding
- Could establish entire practice for prevention
- Need better educational resources
- Ability to tailor information to individuals
- Currently use the Blurb Approach—a blurb here, a blurb there

Counseling & Behavior Change

- Have to begin with pt’s AWARENESS of risk
  - Get data
  - Describe clearly to pt so he understands
- Strong messages about the ability to reduce risks—you can be successful—genetics is not destiny (genetics loads the gun but you have to pull the trigger)
- Readiness to Change assessment
  - Transtheoretical Change Model (Prochaska)
- Clear information about behavior changes to reduce risk
- Use of Motivational Interviewing techniques
- Access & availability of resources (referrals, handouts, dietitians, etc)
Counseling & Behavior Change (cont)

• It isn’t always easy, although it is always possible to do something
• Need effective counseling model to assist pts to change behavior
  - Motivational Interviewing techniques
  - Linked to stage of readiness to change
  - Others
  * cognitive-behavioral approach
  * Health Beliefs model (barriers, self-efficacy, personal risk, benefits)

Tips for Prevention Programs
The Practice
• Make a clear commitment to prevention
• Use a team approach (build it into routine care)
  - MA protocol to implement orders
• Plan a structure & process
  - EHR summary and/or reminders (decide guides)
  - Paper template/summary
  - Provider notifications & performance feedback
  - Patient notifications
  - Have an RN manage Population Prevention per protocol

Tips for Prevention Programs
The Patient
• Explain and get an agreement with your patient to consider prevention
• This is “integral part of our practice”
• Create/Negotiate a personalized plan (EHR, paper, etc)
• Execute, monitor, and review
• Seek patient feedback as to most effective and preferred strategies (individual and groups)
Time for fun…….

- MINI CASES 1 & 2

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